U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 29 April 2004

In the Matter of:

WILLIAM A. MUIR,
Claimant,

CASE NO: 2003 BLA 5110

v.

OLD BEN COAL COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Appearances:

William A. Muir
pro se

Gary B. Nelson, Esquire
For the Employer

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

Statement of the Case

This proceeding involves a claim for benefits under the Black Lung Benefits Act as amended, 30 U.S.C. §901 *et seq.* (the Act), and the regulations promulgated thereunder.[1] Since Claimant filed this application for benefits after March 31, 1980, Part 718 applies. Since the claim was pending on the effective date, January 19, 2001, of the amendments to Parts 718 and 725, consideration of the claim is governed by the amendments in accordance with their terms.[2] This claim is governed by the law of the Seventh Circuit of the United States, since Claimant

[1] All applicable regulations which are cited in this Decision and Order are included in Title 20, Code of Federal Regulations, and are cited by part or section only. The Director's exhibits are denoted, "D-"; and Employer's exhibits, "E-".

[2] In an order dated September 11, 2003, this tribunal determined that this claim is a modification claim to be decided under the pre-amended regulations, where applicable.

was last employed in the coal industry in Illinois. *See Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

Procedural History

William A. Muir (the "Claimant") filed his first claim for benefits under the Act on April 23, 1973. (D-1-22)[3] He was ultimately denied benefits by the District Director on May 1, 1980. (D-1-22)

Claimant filed a subsequent claim for benefits on February 2, 1983. (D-1-1) On April 20, 1983 the District Director denied benefits to Claimant. (D-1-19) Claimant requested a formal hearing by an administrative law judge on May 5, 1983. (D-1-21) In a Decision and Order dated November 4, 1986, Administrative Law Judge Michael F. Colligan denied benefits because Claimant had not proved that he had pneumoconiosis, that it was caused by coal mine employment, that he was totally impaired by a respiratory or pulmonary disease, or that he was totally impaired by pneumoconiosis. (D-1) On appeal, the Benefits Review Board affirmed in a Decision and Order dated July 19, 1988.[4] (D-1)

Claimant filed a second subsequent claim for benefits on August 1, 2000. (D-2) The Director denied benefits on October 12, 2000, because Claimant had not proved that his pneumoconiosis was caused by coal mine work, or that he was totally disabled by pneumoconiosis.[5] (D-2) Claimant did not request a hearing or take other action within thirty days of the decision. Claimant filed another claim on October 10, 2001, which was treated by the Director as a timely request for modification under the amended regulations. (D-3, 4) In a Proposed Decision and Order dated September 5, 2002, the Director denied Claimant's request for benefits.[6] (D-36) In a letter filed September 19, 2002, Claimant requested a formal hearing before an administrative law judge. (D-38) The parties agreed to waive their rights to a formal hearing, the hearing was cancelled, and this tribunal directed a decision on the written record in an order dated September 10, 2003.[7]

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[3] This tribunal has included corresponding exhibit numbers when present in the file.

[4] There is no letter in the file asking for an appeal.

[5] The Director incorrectly treated the previous claim as an initial claim, instead of a subsequent claim, as it was required to do. Therefore, it did not find that there was a change in conditions, instead finding that Claimant had proved pneumoconiosis, but none of the other necessary elements to entitlement.

[6] At the time, the Director was treating the claim as a subsequent claim under the amended regulations. (D-26) However, Employer repeatedly challenged the status of the claim as new by correspondence and pretrial motions, and declared that it would treat the claim as a modification of the prior denial. (D-25, 29, 33, 35) In letters dated July 9, and 23, 2002, the Director declared that it deemed the claim to have been filed November 19, 2001, and would be processed under the new procedures. (D-32, 34, 36) However, by letter dated August 29, 2003, the Director, by counsel, conceded that Claimant's pending application for benefits should be considered a request for modification of the prior denial pursuant to §725.309(c) [§725.309(d) under the pre-amended regulations] to be adjudicated under the regulations effective on August 1, 2000. This tribunal so ordered on September 11, 2003.

[7] This tribunal received Director's exhibits one through forty-three as part of the claim; Employer timely submitted Employer's exhibits one through eleven; and the exhibits have been admitted into the record.

Issues

1. Whether Claimant has proved the existence of a change of conditions since the denial of his claim by the District Director on October 12, 2000, or a mistake in a determination of fact?
2. Whether Claimant's pneumoconiosis arose from his coal mine employment?
3. Whether Claimant is totally disabled by a respiratory or pulmonary impairment?
4. Whether Claimant's total disability, if proved, is due to coal workers' pneumoconiosis?

Findings of Fact

Background

Claimant was born August 1, 1916, and completed the eighth grade of education. (D-3) Claimant alleged that he completed thirty-nine years of coal mine employment, ending in 1983. (D-3) Claimant's social security and work records indicate that Claimant completed thirty-eight years of coal mine employment; this tribunal so finds. (D-7, 8) Claimant last worked in the coal mining industry as a bottom laborer for Old Ben Coal Company (the "Employer") in 1983. (D-3, 7, 8) In an Agreed Order Amending Issues in Controversion dated June 6, 2003, Employer stipulated to being the responsible operator in this case. Claimant has no dependents. (D-3)

Evidence Submitted Since the Denial of Claimant's Subsequent Claim on October 12, 2000

X-ray Evidence[8]

Exh. No.	X-ray Date	Physician	Qualifications	Film Quality	Interpretation
D-21	2/10/99	Wiot	R/B	2	0/0[9]
D-21	3/7/00	Wiot	R/B	3	0/0[10]
E-3	9/25/01	Wiot	R/B	1	3/2, p/q[11]

[8] The following abbreviations are used in describing the qualifications of the physicians: B-reader, "B"; board-certified radiologist, "R"; board-eligible radiologist, "E". An interpretation of "0/0"signifies that the film was read as completely negative for pneumoconiosis. A series of x-rays taken in February and March 1999, and read by Dr. Biermann, some of which were of the chest, related to a gallbladder hospital admission, and were nonconforming, not classified, and without identified etiology. (D-20) Dr. Biermann noted extensive abnormal reticular nodular type opacities throughout both lungs, possibly related to "fairly extensive chronic interstitial lung disease," and hyperinflation consistent with a component of chronic obstructive pulmonary disease. (D-20)

[9] This x-ray was read on February 13, 2002. However, because it is a reading of an x-ray dated before the previous denial, it does not weigh to change of conditions.

[10] This x-ray was read on February 13, 2002. However, because it is a reading of an x-ray dated before the previous denial, it does not weigh to change of conditions

[11] Dr. Wiot opined that this was a very abnormal chest x-ray, and the character and distribution of small opacities were much more consistent with interstitial pulmonary fibrosis, than with coal worker's pneumoconiosis (CWP). There was significant disease present within the left mid and left lower lung fields, with relative sparing of the left upper lung field. On the right, the most prominent involvement was in the right upper lung field. There were also

Exh. No.	X-ray Date	Physician	Qualifications	Film Quality	Interpretation
E-6	9/25/01	Renn	B	2	3/2, t/q[12]
D-17, 18	3/5/02	Marmo	E	Not noted	0/0
D-19	3/5/02	Sargent	R/B	2	Film read for quality only
E-3	3/5/02	Wiot	R/B	1	3/3, p/q, size A large opacities[13]
E-5	7/30/02	Wiot	R/B	1	3/2, p/q[14]
E-6	7/30/02	Renn	B	2	3/2, t/q[15]

Pulmonary Function Studies

Exh. No	Test Date	Age/ Ht	Doctor	Co-op/ Unds./ Conf.?	FEV1	FVC	MVV	Qualify
D-16	3/5/02	85/ 71.8"	Sanjabi	Good/ Good Yes	2.81	3.63	-	No

changes within both mid and lower zones of a lesser degree. There was associated honeycombing noted in the right upper and left lower lung fields, and Dr. Wiot opined that honeycombing is not a manifestation of coal dust exposure. Dr. Wiot declared that honeycombing can be seen in asbestosis, but there were no pleural plaques to suggest a past history of asbestos exposure, and the magnitude of interstitial change would be unusual in asbestosis without pleural plaques. There were no definite large opacities.

[12] Dr. Renn opined that this x-ray revealed honeycombing.

[13] Dr. Wiot declared that he had a strong question that what he classified as pneumoconiosis may be some other disease process, most likely interstitial pulmonary fibrosis, because of the character and distribution of the process. There was relative sparing of the left upper lung field, with the left base being markedly involved, and the right mid and lower lung fields less involved than the right upper lung field. Dr. Wiot opined that he felt "strongly" that the findings were most likely due to interstitial pulmonary fibrosis, and "not" CWP.

[14] Dr. Wiot opined that this was a very abnormal chest x-ray. The findings were much more compatible with asbestosis or interstitial pulmonary fibrosis than with CWP. This distribution of small opacities was primarily at the left base and left mid lung field with sparing of the left upper lung field. On the right, there was involvement of all areas with the right upper zone being the most involved. There was associated honeycombing noted bilaterally, and Dr. Wiot opined that honeycombing is not a manifestation of coal dust exposure. The character of this change was much more consistent with interstitial pulmonary fibrosis than with CWP. The lack of pleural plaques was against a diagnosis of asbestosis, particularly with the magnitude of interstitial change. There was a slight prominence of the central pulmonary vessels, which would raise the question of pulmonary hypertension. The lung fields suggested over-expanding consistent with emphysema. Dr. Wiot declared that he felt "strongly" that the x-ray readings did not represent CWP, in view of the distribution and presence of honeycombing.

[15] Dr. Renn opined that this x-ray revealed honeycombing.

Arterial Blood Gas Studies

Exh. No.	Test Date	Physician	Conform?	pO2	pCO2	Qualifying
D-15	3/5/02	Sanjabi	Yes	40.1	79.3	No

CT Scans

Exh. No.	Test Date	Physician	Interpretation
D-21	3/4/99	Wiot	CT scans were very abnormal, but there were no findings of coal workers' pneumoconiosis (CWP). There was presence of interstitial changes at both bases, greater on the left than on right. There were also emphysema changes.

Medical Reports and Opinions

Dr. Rhody D. Eisenstein[16]

In connection with a medical report dated September 19, 2000, Dr. Eisenstein, who is board-certified in internal medicine and the subspecialty of pulmonary disease, reviewed specified medical records and examined Claimant. Dr. Eisenstein noted that Claimant had been a coal miner for forty years and that he was a nonsmoker. Upon examination of Claimant's lungs, Dr. Eisenstein observed resonant percussion auscultation, which revealed extensive fine "Velcro" interstitial type crackles. Dr. Eisenstein opined that Claimant had extensive progressive interstitial lung disease, which "could be" related to pneumoconiosis from his previous mining. Dr. Eisenstein opined that unspecified CT images suggested that there was end stage fibrosis and honeycombing and probably little in the way of active ongoing inflammation. Dr. Eisenstein opined that there were asthmatic type symptoms superimposed on Claimant's interstitial lung disease. Dr. Eisenstein suspected that Claimant had cor pulmonale, but could not tell what his left ventricular function was, either clinically or radiographically. (D-11)

Dr. Saeed A. Khan

In connection with a medical report dated September 26, 2001, on referral from Dr. Sanjabi, Dr. Khan, who is board-certified in internal medicine, examined Claimant. Dr. Khan noted that Claimant worked underground in the coal mines for forty years in an excessive amount of coal dust as a shuttle car operator, roof bolter, and machine operator, and stopped working in 1983. Dr. Khan noted that Claimant smoked one pack of cigarettes daily for five

[16] Dr. Eisenstein's report was received on October 10, 2001. However, since it was dated before the previous denial, it does not weigh to change of conditions.

years and he stopped smoking in 1956. Dr. Khan declared that Claimant had prolonged expiration, bilateral inspiratory and expiratory rhonchi, and bilateral medium crepitations on both lung fields due to advanced pulmonary fibrosis. Dr. Khan opined that an x-ray taken on September 25, 2001, showed advanced interstitial pulmonary fibrosis, reticular fibrosis, and severe emphysema, and miliary mottling in both lung fields, which suggested progressive massive fibrosis and complicated coal workers' pneumoconiosis (CWP). An arterial blood gas study performed on September 25, 2001, suggested hypercapnia and hypoxemia consistent with emphysema and CWP. A pulmonary function study performed on the same day suggested moderate emphysema and pulmonary fibrosis. Dr. Khan concluded that Claimant had advanced CWP, severe pulmonary emphysema, and pulmonary fibrosis. Dr. Khan opined that Claimant was totally disabled due to CWP and pulmonary emphysema. (D-12)

Dr. P. B. Sanjabi

In connection with a medical report dated March 5, [2002], Dr. Sanjabi, whose qualifications could not be located in the record or on the internet, examined Claimant. Dr. Sanjabi noted that Claimant had at least twenty-three years of coal mine employment, working as a motor man, laborer, shuttle car operator, bottom laborer, and track layer, and stopped working in 1983. Dr. Sanjabi recorded that Claimant smoked one half pack of cigarettes a day from 1932 to 1942. Dr. Sanjabi observed inspiratory rales bilaterally upon examination of Claimant's lungs. Dr. Sanjabi read an x-ray dated March 5, 2002 as 3/2, positive for pneumoconiosis. Dr. Sanjabi diagnosed Claimant with CWP, "fibrosis suggested by examination (not supported by limited pulmonary function study)," and "CAD?" (coronary artery disease). Dr. Sanjabi opined that the CWP and fibrosis were caused by "exposure to coal" and the coronary artery disease was caused by other conditions. Dr. Sanjabi opined that the pulmonary function test did not support a limitation but that "it must be considered that this level of testing is a poor indicator of exercise tolerance." Dr. Sanjabi declared that he suspected that Claimant's lungs contributed to his impairment, but the amount of the contribution was unknown. Dr. Sanjabi did not opine as to the extent of Claimant's impairment. Dr. Sanjabi opined that the status of Claimant's heart needs evaluation and that Claimant could not do an exercise test. (D-13)

In a referral letter to Dr. Khan dated March 5, 2002, Dr. Sanjabi opined that Claimant had a diffused pulmonary pattern that required evaluation. He also noted that Claimant had chest pain with activities suggestive of angina pectoris and coronary artery disease. (D-14)

Dr. Joseph J. Renn III

In connection with a medical report dated March 31, 2003, Dr. Renn, who is board-certified in internal medicine and the subspecialty of pulmonary disease, and is a B-reader, reviewed specified medical records. Dr. Renn noted that Claimant worked in and around underground coal mines from 1944 to 1983 as a track layer, bottom laborer, shuttlecar operator, motorman, locomotive switchman, repairman, and, "lastly," bottom cager. Dr. Renn noted that Claimant had a five pack-year smoking history, and stopped smoking sometime between 1940 and 1956.

Dr. Renn declared that Claimant's respiratory system was found to be normal until June 28, 2000, at which time, Claimant was found to have a prolonged expiratory phase, bilateral scattered expiratory rhonchi, and bilateral crepitations. Dr. Renn noted that the bilateral crackles persisted through, at least, March 5, 2002. Dr. Renn opined that the ventilatory function represented by the pulmonary function studies was normal. Dr. Renn opined that the most recent arterial blood gas studies at the time of his review were completely normal, with the oxygen tension actually in excess of that expected for Claimant's age. Dr. Renn diagnosed Claimant with, *inter alia*, interstitial pulmonary fibrosis, "probably" usual interstitial pneumonitis histopathologic type. Dr. Renn opined that Claimant has normal ventilatory function and that pneumoconiosis does not exist in Claimant. Dr. Renn opined that Claimant's interstitial pulmonary fibrosis was neither caused, nor contributed to, by his exposure to coal mine dust. Dr. Renn declared that interstitial pulmonary fibrosis is a respiratory disease of the general population not related to any occupation, and coal mine dust is not known as an etiologic factor. Dr. Renn concluded that Claimant was not totally and permanently impaired by pulmonary factors to the extent that he would be unable to perform any of the coal mining jobs listed under his occupational history or any similar work effort. However, Dr. Renn opined that, when considering the whole man, Claimant was impaired due to his advanced age. (E-1)

In a deposition dated June 5, 2003, Dr. Renn opined that he was able to distinguish Claimant's interstitial pulmonary fibrosis as not CWP, because Claimant's spirometry study showed no restrictive or obstructive ventilatory defect, and an arterial blood gas study showed no interference with gas exchange. Dr. Renn declared that this is consistent with an early or even a "burnt-out" type of interstitial pulmonary fibrosis that is not CWP, and if Claimant had CWP, then he would have had some exercise induced hypoxemia. In addition, the radiographic readings were of irregular opacities found in the interstitial pulmonary fibrosis not usually associated with CWP. Dr. Renn opined that the honeycombing present in Claimant's lungs is not seen in CWP, and indicated Claimant had a fibrotic lung disease that caused some changes in the airways and are known as the "end-stage" type of lung disease, meaning that the disease is no longer active. Dr. Renn opined that he could not determine the etiology of Claimant's lung disease or idiopathic pulmonary fibrosis without an open-lung biopsy, but could rule out CWP based on the current evidence at the time of his review. Dr. Renn opined that even though he read an x-ray as positive for pneumoconiosis, there were no opacities that were distinct enough to absolutely ascertain that there was a diagnostic pneumoconiosis present. Because the opacities were irregularly shaped, Dr. Renn opined that they were similar to opacities caused by asbestos; however, he ruled out asbestos as a cause of the opacities, because Claimant had no history of exposure to asbestos. Dr. Renn opined that x-ray readings from 1983 showed little or no irregular opacities, which demonstrated that, because Claimant had not been exposed to coal mine dust since 1983, and because Claimant was over sixty-five, the most likely cause of the fibrosis was age. Dr. Renn opined that Claimant had the respiratory capacity to perform his previous coal mine job. Dr. Renn disagreed with Dr. Khan's opinion from March 5, 2003, that Claimant suffered from chronic emphysema, because there was no radiographic evidence, or evidence from pulmonary function or arterial blood gas studies that showed evidence of emphysema. Dr. Renn disagreed with Dr. Khan's assessment that emphysema prevented Claimant from being able to walk one block, attributing it instead to Claimant's osteoarthritis and right knee surgery. Dr. Renn opined that Claimant would be "essentially" the same if he had never worked in the coal mines. (E-7)

In preparation for a deposition dated October 2, 2003, Dr. Renn reviewed Dr. Khan's medical opinion dated September 26, 2001, and other related materials. Dr. Renn opined that Dr. Khan's finding of complicated CWP in Claimant was incorrect, because the x-ray that Dr. Khan referred to did not have any large opacities greater than one centimeter on it. Dr. Renn opined that Dr. Khan's diagnosis that the blood gas studies suggested hypoxemia and hypercapnia consistent with emphysema and CWP were "patently wrong" because, when adjusted for his age, Claimant's blood gas study results were normal. Dr. Renn opined that Dr. Khan was incorrect in finding that Claimant had emphysema and pulmonary fibrosis. Emphysema is an obstructive ventilatory defect, but Claimant did not have an obstructive pattern based on his pulmonary function study; and pulmonary fibrosis is a restrictive ventilatory defect, but Claimant did not have a restrictive pattern based on his pulmonary function study. However, based on the irregular opacities found on the x-ray of Claimant's lungs and lack of ventilatory dysfunction, Dr. Renn opined that Claimant had an idiopathic interstitial pulmonary fibrosis, which is developed by people of Claimant's age and may not cause any ventilatory dysfunction, and is not caused by inhalation of coal dust. Dr. Renn opined that Claimant did not have pulmonary emphysema. (E-10)

Dr. Peter G. Tuteur

In connection with a medical report dated February 24, 2003, Dr. Tuteur, who is board-certified in internal medicine and the subspecialty of pulmonary disease, reviewed specified medical records and noted that Claimant worked in the coal mine industry for forty years until 1983. He noted that Claimant worked almost exclusively as an underground miner as a repairman, shuttle car operator, motor man, roof bolter, and at the end, a cageman. Dr. Tuteur opined that Claimant was exposed to sufficient amounts of coal mine dust to produce CWP in a susceptible host. Dr. Tuteur recorded that Claimant smoked "only about" one half pack of cigarettes per day for "about" ten years, and that it was unlikely that he smoked cigarettes after the mid 1940's.

Dr. Tuteur declared that Claimant's chest examinations were persistently abnormal because of basilar crackling sounds, rhonchi and occasional wheezes, with some reviewers reporting prolongation of expiration. Dr. Tuteur opined that Claimant's pulmonary function studies were "striking in their normalcy…and stability" and for twenty-five years, numerical data were within normal limits for spirometry, maximum voluntary ventilation, and arterial blood gas analysis conducted both at rest and during exercise. Dr. Tuteur opined that Claimant did not have decreased total lung capacity or decreased FVC as a reflection of a restrictive abnormality one expects to find when CWP is sufficiently advanced to produce impairment of pulmonary function. Dr. Tuteur declared that chest radiographs were most often interpreted as associated with an interstitial pulmonary process and that the interstitial changes were not typical of those seen with CWP. Dr. Tuteur concluded that Claimant's crackling sounds, normal pulmonary function studies, changing interstitial pulmonary process, recurrent "pneumonias," and recurrent bronchitis were caused by "decades" of recurrent uncontrolled gastroesophageal reflux with acid aspiration and inflammatory changes. Dr. Tuteur opined that the acid reflux causes recurrent bronchial syndrome and some irreversible interstitial changes, while other interstitial changes, reflecting an acute inflammatory process, are reversible. Dr. Tuteur opined that the pulmonary

function studies and arterial blood gas studies refute that there is an obstructive abnormality of any magnitude or an impairment of gas exchange.

Dr. Tuteur opined that Claimant's breathlessness, which is the "quintessential" clinical feature of CWP, is a highly nonspecific finding consistent with virtually any primary pulmonary or cardiac disorder, and may also occur with musculoskeletal disorders. Dr. Tuteur opined that Claimant's reconstructed knee, his cardiac disorder, and gastroesophageal reflux disease with aspiration caused Claimant's breathlessness. Dr. Tuteur concluded that the medical data did not reflect the information supportive of a diagnosis of CWP or any other coal mine dust-induced disease process of sufficient severity and magnitude to produce clinical symptoms, physical examination abnormalities, impairment of pulmonary function, or an abnormal radiograph. Dr. Tuteur opined that Claimant did not suffer from a totally disabling pulmonary or respiratory impairment, and "in fact" had no demonstrable pulmonary or respiratory impairment. Dr. Tuteur declared that any disability that Claimant had, was not related to coal dust exposure and that he did not have cor pulmonale. Dr. Tuteur opined that the clinical data set would be no different had Claimant never worked in the coal mine industry. (E-2)

In a deposition dated June 24, 2003, Dr. Tuteur opined that he did not know the cause of Claimant's pulmonary fibrosis, i.e. idiopathic pulmonary fibrosis; however, he knew that the cause of the fibrosis was not CWP, because Claimant's chest radiograph had abnormalities in areas that are not typical for CWP, and his radiographs were not abnormal following discontinuation of exposure to coal mine dust and only became abnormal in 1989, six years after Claimant discontinued work. Dr. Tuteur opined that based on a review of Dr. Sanjabi's records, from 1989 to the time of the deposition, that Claimant had gastroesophageal reflux, which would cause aspiration of gastric contents into the lungs, which in turn initiates an inflammatory process causing a fibrotic process as it heals. The symptoms are breathlessness and do not cause impairment of pulmonary function. (E-9)

Other Medical Evidence

Dr. Jerome F. Wiot

In connection with a deposition dated June 18, 2003, Dr. Wiot reviewed his x-ray readings from February 10, 1999 to July 20, 2002. He opined that the x-rays were more consistent with interstitial pulmonary fibrosis than with CWP because the distribution of opacities in Claimant's lungs started in the base of his lungs, rather than the top of the lungs, as it would with CWP. Dr. Wiot opined that to have the number of opacities in lower lung fields, but not in upper lung fields, as it was with Claimant, "just doesn't happen" with pneumoconiosis. Dr. Wiot declared that he interpreted the x-rays as positive for pneumoconiosis because the ILO rules require that he document any opacities that resemble pneumoconiosis. Dr. Wiot also opined that the opacities were irregularly shaped, and were not the rounded opacities usually associated with CWP. Dr. Wiot opined that the opacities looked very similar to those caused by asbestosis, but he knew Claimant had not been exposed to asbestosis, and there was no pleural thickening as would be present in asbestosis of this magnitude, so he ruled asbestosis out as a cause. Dr. Wiot opined that Claimant had an idiopathic pulmonary fibrosis, because he did not know the cause of the fibrosis. Dr. Wiot observed honeycombing in Claimant's lungs, which is

not present in those with coal workers' pneumoconiosis. Dr. Wiot observed a large opacity in Claimant's lungs in the March, 2002, x-ray but did not see the opacity in any other x-ray. Dr. Wiot opined that the large opacity could have been a summation shadow resulting from various vessels and bronchi coming together to form the image of a nodule. There were no significant changes in the fibrosis from one x-ray to the next. Dr. Wiot opined that a reading of a 1999, CT Scan confirmed his opinion that Claimant did not have coal worker type opacities and he did not see the presence of any large opacity. (E-8)

Hospital Records

In a series of medical care and treatment reports dated from December, 1990 to November, 2000, Claimant was diagnosed with chronic obstructive pulmonary disease ("COPD"). Extensive abnormal reticular nodular type opacities, possibly related to fairly extensive chronic interstitial lung disease, were noted throughout both lungs. A slightly more confluent opacity was noted at the left lung base and early left basilar pneumonia could not be excluded. A superimposed pneumonic infiltrate was noted in the right upper lobe. Generally, the medical reports dealt with the general status of Claimant's health. (D-20)

Conclusions of Law and Discussion

Modification: Change in Conditions or Mistake in a Determination of Fact

Section 725.310 provides that any party may request modification of an award or denial of benefits if such request is filed within one year of the denial alleging a change in conditions or mistake in a determination of fact. Under §725.419(d), a Director's decision and order becomes final, if no response to a proposed decision and order is sent within 30 days after the date of issuance, effective upon the expiration of the applicable 30-day period. Where mistake in a determination of fact forms the grounds for the modification request, new evidence is not a prerequisite, and a mistake in a determination of fact may be corrected whether demonstrated by new evidence, cumulative evidence, or further reflection on evidence initially submitted. *Kovac v. BCNR Mining Corporation,* 16 B.L.R. 1071 (1992), *modifying* 14 B.L.R. 1-156 (1990). Even if no new evidence is submitted, or newly submitted evidence does not support a change in condition, the fact-finder must review the entire record to determine whether a "mistake in a determination of fact" has been made. *See Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992). The administrative law judge, as trier-of-fact, has the authority, and the duty, to review the evidence of record *de novo* and is bound to consider the entirety of the evidentiary record, not merely the newly submitted evidence, in making the finding upon modification. *See Nataloni v. Director, OWCP*, 17 B.L.R. 1-82, 1-84 (1993); *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156 (1990), *modified on reconsideration*, 16 B.L.R. 1-71 (1992); *Jessee v. Director, OWCP*, 5 F.3d 723, 725, 18 B.L.R. 2-26, 2-28 (4th Cir. 1993); *see generally, O'Keeffe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971).

A change in conditions focuses on whether there has been a change of the miner's condition. In determining whether a change in conditions has occurred, an administrative law judge must "perform an independent assessment of the newly submitted evidence, in conjunction with evidence previously submitted, to determine if the weight of the new evidence is sufficient

to establish the element or elements which defeated entitlement in the prior decision." *See Nataloni v. Director. OWCP*, 17 B.L.R. 1-82, 1-84 (1993); *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994); *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993).

Mistake in a Determination of Fact

Claimant was denied benefits by the District Director on October 12, 2000, because Claimant had not proved that his pneumoconiosis was caused by coal mine work, that he was totally disabled by a pulmonary or respiratory disease, or that he was totally disabled by pneumoconiosis. Having reviewed *de novo* the evidence that was before the Director prior to the denial, and the newly submitted evidence, this tribunal has determined that the Director correctly found that Claimant did not establish the necessary elements of entitlement. The evidence relevant to the claim that was before the Director consisted of seventeen readings of four x-rays, nine as negative for pneumoconiosis and eight as positive; two arterial blood gas studies, neither of which are qualifying; two pulmonary function studies, both nonqualifying; and the medical opinions of Drs. Rao, Ferguson, Levitt, Khan, and Sanjabi.

The three readings of the September 5, 2000, x-ray, which was the most recent x-ray taken in connection with the previous claim, the second most recent taken in 1985, were all read as positive for pneumoconiosis, one by a dually qualified radiologist and B-reader, one by a B-reader, and one by a board-eligible radiologist.[17] While nine x-ray readings were negative for pneumoconiosis, those x-rays were all read in 1985 or earlier. The most recent x-ray evidence proved that Claimant had pneumoconiosis. In addition, Drs. Rao, Khan, and Sanjabi opined that Claimant had pneumoconiosis.[18] Therefore, the x-ray evidence before the Director supported a finding that Claimant had a type of pneumoconiosis, and the finding is consistent with the opinions of Drs. Rao, Khan, and Sanjabi. Thus, despite the District Director's incorrect treatment of the previous claim as an initial claim, it also correctly found that there had been an implicit material change in conditions since the prior denial by Judge Colligan in 1986.

Claimant had established at least ten years of coal mine employment and he was entitled to the rebuttable presumption that his pneumoconiosis arose from his coal mine employment. Drs. Rao, Khan, Sanjabi all opined that Claimant's pneumoconiosis was caused by coal mine dust. In a reading with well reasoned comments dated September 5, 2000, Dr. Wiot opined that Claimant had interstitial fibrosis, but that it was not caused by coal mine dust, because only the mid and lower lung fields were involved, and the changes were those of irregular opacities with associated honeycombing. Dr. Wiot opined that under the ILO rules, he was required to classify Claimant's small opacities as being consistent with pneumoconiosis, but that it was "definitely" not coal workers' pneumoconiosis. Drs. Ferguson and Levitt only commented on Claimant's sensitivity to coal mine dust, and did not opine whether the exposure caused CWP. It is not

[17] Dr. Wiot's opinion that the pneumoconiosis was not coal workers' pneumoconiosis goes to the etiology of the disease, not whether Claimant had pneumoconiosis, and has been weighed accordingly. *See Cranor v. Peabody Coal Company*, 22 B.L.R. 1-1 (1999)(*en banc* on recon.)(a physician's comments that address the source of a pneumoconiosis diagnosed by x-ray are not relevant to the issue of the existence of pneumoconiosis at §718.202(a)(1); rather, those comments are to be considered at §718.203.)

[18] Dr. Levitt did not opine that Claimant had pneumoconiosis, only that he had a pulmonary condition that would worsen with continued dust exposure. Dr. Ferguson opined that Claimant had bronchitis that "may be" caused by coal mine dust.

apparent on what basis Dr. Rao relied in diagnosing Claimant as having pneumoconiosis, so that his opinion is not well reasoned or based on the medical data of record, and it is unclear how he determined the etiology of the pneumoconiosis. Dr. Khan based his finding of CWP on an x-ray allegedly dated February 28, 2000, and an unidentified, nonqualifying blood gas study in finding that Claimant's pneumoconiosis was caused by coal mine employment. Dr. Khan did not reconcile the nonqualifying blood gas study results, with his finding of pneumoconiosis. In addition, Dr. Khan relied on an x-ray that is not a part of the record in finding that Claimant had pneumoconiosis, and the qualifications of the physician reading the x-ray that he relied on cannot be determined. Therefore, Dr. Kahn's opinion is not reasoned or based on the medical data of record, so that his finding that Claimant had pneumoconiosis was caused by his coal mine employment is not supported by the medical evidence and is considered unreasoned. Dr. Sanjabi's opinion is equivocal because he only stated that coal workers' pneumoconiosis could not be ruled out, and his opinion is given little weight. Dr. Wiot is a board-certified radiologist and a B-reader. Therefore, Dr. Wiot's x-ray reading and his emphatic opinion excluding coal mine dust as the etiology of the fibrosis or coal mine employment as the cause of Claimant's lung abnormalities is given the most weight. The Employer thus rebutted the presumption of causation, and the evidence before the Director did not support a finding that Claimant's pneumoconiosis was caused by coal mine employment.

There were no qualifying pulmonary function study results or arterial blood gas study results before the Director. Dr. Khan opined that Claimant was totally disabled by a pulmonary or respiratory disease, but he did not reconcile his opinion with the non-qualifying pulmonary function studies and arterial blood gas studies of which he was aware. None of the other physicians opined that Claimant had any disability that would prevent him from returning to his previous coal mine employment. As previously noted, Dr. Khan relied on an x-ray that is not a part of the record and the medical evidence does not support his findings, so that his opinion regarding total disability is considered unreasoned. Thus, the evidence before the Director did not support a finding of total disability caused by a pulmonary or respiratory disease or by pneumoconiosis. Because a review of the evidence of record has not disclosed a mistake in a determination of fact in finding that Claimant's pneumoconiosis was not caused by coal mine employment, that he was not totally or permanently disabled by a pulmonary or respiratory disease, or that he was totally disabled by pneumoconiosis, Claimant's request for modification, to the extent it is based on a mistake in a determination of fact, must be denied.

Change in Conditions

Causation

In denying benefits on October 12, 2000, and September 5, 2002, the District Director determined that Claimant had proved the existence of pneumoconiosis, but not a causal connection of the pneumoconiosis with his coal mine work. The evidence previously of record established that Claimant had more than ten years of coal mine employment, which entitled him to invoke the rebuttable presumption under §718.203(b), that his pneumoconiosis was caused by that coal mine employment. Employer, however, has rebutted that causal nexus by proving by a preponderance of the new medical evidence, particularly the opinions of Dr. Renn and Dr. Tuteur, that Claimant's pulmonary disease is not related to coal dust exposure or coal mine

employment. There is no evidence that Claimant resumed coal mine employment which could have caused his pneumoconiosis after his retirement in 1983. Therefore there has not been new proof of the element of causation which was previously adjudicated against the Claimant, and there is no change of conditions in this regard.

A change in conditions refers to a change in the claimant's physical condition. *Lukman v. Director, OWCP*, 11 B.L.R. 1-71 (1988)(*Lukman II*). In addition, this tribunal must assess the newly submitted evidence and consider it in conjunction with the previously submitted evidence to determine whether the weight of the new evidence is sufficient to demonstrate an element or elements of entitlement previously adjudicated against the Claimant. *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994). Demonstrating causation would not be a physical change in Claimant's condition, so that Claimant cannot prove a physical change in condition through causation. However, if Claimant proved that he has worked in the coal mines since the previous denial by the District Director, it would demonstrate an element of entitlement previously adjudicated against Claimant, thus proving a change in conditions. Claimant has not worked in the coal mines since his previous denial. Therefore, Claimant has not proved a change of conditions by causation.

Disability Due to Pulmonary or Respiratory Disease

To establish total disability, Claimant must prove that he is unable to engage in either his usual coal mine work or comparable and gainful work as defined in §718.204. Section 718.204(b)(2) provides that the criteria for determining whether a miner is totally disabled are: (1) pulmonary function tests qualifying under applicable regulatory standards; (2) arterial blood gas studies qualifying under applicable regulatory standards; (3) proof of pneumoconiosis and cor pulmonale with right sided congestive heart failure; or (4) proof of a disabling respiratory or pulmonary condition on the basis of the reasoned medical opinion of a physician relying upon medically acceptable clinical and laboratory diagnostic techniques. If there is contrary evidence in the record, all the evidence must be weighed in determining whether there is proof by a preponderance of the evidence that the miner is totally disabled by pneumoconiosis. *Shedlock v. Bethlehem Mines. Corp.*, 9 B.L.R. 1-95 (1986).

One pulmonary function study, which conformed to the regulations, is included with the new evidence, and it produced a non-qualifying result. Therefore, a preponderance of the pulmonary function study evidence does not establish total disability pursuant to §718.204(b)(2)(i). One conforming arterial blood gas study was included in the new evidence, and it produced a non-qualifying result as well. Therefore, the preponderance of the arterial blood gas study evidence does not establish total disability pursuant to §718.204(b)(2)(ii). There is no proof of cor pulmonale and, therefore, Claimant has not proved total disability pursuant to Section 718.204(b)(2)(iii).[19]

The medical opinions of the physicians who examined Claimant and reviewed specified medical evidence do not establish that Claimant is totally disabled by a respiratory or pulmonary impairment pursuant to §718.204(b)(2)(iv). Drs. Tuteur and Renn opined in well reasoned

[19] Dr. Eisenstein opined that Claimant possibly had cor pulmonale, but because his opinion was dated September 19, 2000, before the previous denial, his opinion does not weigh against change of conditions.

opinions supported by the medical evidence that Claimant was not disabled by a pulmonary or respiratory disease, and that he retained the respiratory capacity to perform his previous coal mine employment. Dr. Khan opined that Claimant was totally disabled due to CWP and pulmonary emphysema. However, Dr. Khan's opinion is not supported by the medical evidence of record, because no pulmonary function study or arterial blood gas study of record has proved that Claimant was disabled, and Dr. Khan did not reconcile his finding of disability with the nonqualifying studies. Also, his opinion was refuted in most respects by Dr. Renn, who, as a pulmonary specialist, had superior professional qualifications. In an equivocal opinion, Dr. Sanjabi declared that, even though Claimant's pulmonary function study did not support a "limitation," Claimant was impaired, but Dr. Sanjabi did not assess the severity of the impairment or state that Claimant was totally disabled by the impairment. In addition, he did not reconcile his finding of disability with the nonqualifying studies of which he was aware, so that his opinion is not well reasoned. Drs. Renn and Tuteur have better professional qualifications than either Dr. Khan or Dr. Sanjabi, and so their opinions are given greater weight. Therefore, because the preponderance of the evidence under §718.204(b)(iv) indicates affirmatively that the Claimant is not totally disabled by a pulmonary or respiratory impairment, and because the preponderance of the objective evidence under §718.204(b) corroborates and is consistent with that evidence, Claimant has not established that he is totally disabled by a respiratory or pulmonary impairment.

Total Disability Due to Pneumoconiosis

To establish entitlement, a claimant must prove by a preponderance of the evidence that he is totally disabled due to pneumoconiosis. A miner is considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. §718.204(c)(1). Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition, or it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. *Id.* In this case, the preponderance of the evidence does not establish that Claimant was totally disabled by a pulmonary or respiratory impairment. Therefore, the issue of whether the Claimant is totally disabled due to pneumoconiosis is moot.

A claimant is entitled to an irrebuttable presumption of total disability due to pneumoconiosis if the claimant is suffering from a chronic dust disease of the lung which, when diagnosed by a chest x-ray, yields one or more large opacities that would be classified in Category A, B, or C under the ILO-U/C International Classification of Radiographs of the Pneumoconioses, or when diagnosed by biopsy yields massive lesions in the lung. §718.304. Dr. Khan opined in an equivocal opinion that an x-ray taken on September 25, 2001, apparently read by Dr. Khan, "suggested" complicated CWP, because Claimant had miliary mottling in both lung fields, "which suggests" progressive massive fibrosis and complicated CWP. However, he did not discuss his reasoning as to why he diagnosed complicated CWP after finding miliary mottling, nor did he opine that Claimant had any large opacities, and his opinion is considered not well reasoned. Dr. Wiot opined that Claimant had a size A opacity in an x-ray reading dated March 5, 2002. However, he did not observe the opacity in any previous or subsequent x-ray readings, and opined that the large opacity was most likely a summation shadow resulting from

various vessels and bronchi coming together to form the image of a nodule. There is no biopsy or other evidence which would tend to prove the existence of complicated pneumoconiosis under §718.304. Therefore, Claimant has not proved that he had complicated pneumoconiosis, and he is not entitled to the irrebuttable presumption set forth in §718.304 that he is totally disabled due to pneumoconiosis.

The new evidence does not contradict the medical evidence of record previously submitted by the parties, and is not indicative of a change in conditions. No element previously determined unfavorably to Claimant has been proved. Upon review of all of the evidence of record, it has been determined that there has been no mistake in a determination of fact and that Claimant does not have pneumoconiosis. Consequently, Claimant has established no basis that would support his requested modification, or an award of black lung benefits.

ORDER

Claimant's request for modification and claim for black lung benefits are denied.

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EDWARD TERHUNE MILLER
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any interested party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order by filing a notice of appeal with the **Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of the notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor, Room N-2117,